APPENDIX SECTION 27100

DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS UNDER MEDICAID UTILIZATION METHOD OF SECTION 5243

Effective July 1, 1999

Effective July 1, 1999 , a hospital's disproportionate share adjustment factor under section 4243 is calculated according to the following formula where:

18.82%	=	Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate.
M	=	The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than 18.82%.
.0948	=	Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases.

Formula:

[(M - 18.82%) x .0948] + 3% = Hospital's Specific Disproportionate Share Adjustment Percentage

APPENDIX 27200
INFLATION RATE MULTIPLIERS
FOR ADMINISTRATIVE ADJUSTMENTS
FOR RATES EFFECTIVE JULY 1, 1999 THROUGH JUNE 30, 2000

Inflation rates to be applied in calculating the following administrative adjustments of §11900:
Item B -- Capital and direct medical education payment based on cost report more than three years old
Item C -- Capital payment adjustment for major capitalized expenditures
Item D -- Adjustment for changes in medical education

Month Fiscal Year Ended	Inflation Multiplier
1993	
Jan-93	1.2059
Feb-93	1.2059
Mar-93	1.2059
Apr-93	1.1977
May-93	1.1977
Jun-93	1.1977
Jul-93	1.1896
Aug-93	1.1896
Sep-93	1.1896
Oct-93	1.1838
Nov-93	1.1838
Dec-93	1.1838
1994	
Jan-94	1.1748
Feb-94	1.1748
Mar-94	1.1748
Apr-94	1.1681
May-94	1.1681
Jun-94	1.1681
Jul-94	1.1582
Aug-94	1.1582
Sep-94	1.1582
Oct-94	1.1495
Nov-94	1.1495
Dec-94	1.1495
1995	
Jan-95	1.1389
Feb-95	1.1389
Mar-95	1.1389
Apr-95	1.1305
May-95	1.1305
Jun-95	1.1305
Jul-95	1.1233
Aug-95	1.1233
Sep-95	1.1233
Oct-95	1.1192
Nov-95	1.1192
Dec-95	1.1192

Month Fiscal Year Ended	Inflation Multiplier
1996	
Jan-96	1.1121
Feb-96	1.1121
Mar-96	1.1121
Apr-96	1.1061
May-96	1.1061
Jun-96	1.1061
Jul-96	1.0992
Aug-96	1.0992
Sep-96	1.0992
Oct-96	1.0953
Nov-96	1.0953
Dec-96	1.0953
1997	
Jan-97	1.0904
Feb-97	1.0904
Mar-97	1.0904
Apr-97	1.0856
May-97	1.0856
Jun-97	1.0856
Jul-97	1.0771
Aug-97	1.0771
Sep-97	1.0771
Oct-97	1.0696
Nov-97	1.0696
Dec-97	1.0696
1998	
Jan-98	1.0622
Feb-98	1.0622
Mar-98	1.0622
Apr-98	1.0540
May-98	1.0540
Jun-98	1.0540
Jul-98	1.0441
Aug-98	1.0441
Sep-98	1.0441
Oct-98	1.0389
Nov-98	1.0389
Dec-98	1.0389

Month Fiscal Year Ended	Inflation Multiplier
1999	
Jan-99	1.0319
Feb-99	1.0319
Mar-99	1.0319
Apr-99	1.0267
May-99	1.0267
Jun-99	1.0267
Jul-99	1.0191
Aug-99	1.0191
Sep-99	1.0191
Oct-99	1.0140
Nov-99	1.0140
Dec-99	1.0140
2000	
Jan-00	1.0065
Feb-00	1.0065
Mar-00	1.0065
Apr-00	1.0000
May-00	1.0000
Jun-00	1.0000
Jul-00	0.9919
Aug-00	0.9919
Sep-00	0.9919
Oct-00	0.9856
Nov-00	0.9856
Dec-00	0.9856
2001	
Jan-2001	0.9777
Feb-2001	0.9777
Mar-2001	0.9777

26000 Example Calculation - Hold Harmless

APPENDIX SECTION 26000
EXAMPLE CALCULATION – HOLD HARMLESS

The Department has established an automatic one year hold harmless provision for all providers that do not have experience under the Medicare DRG reimbursement system. This is limited to Children's Hospital and hospital IMDs. The hold harmless provision will guarantee that these providers will not receive less under the first year of DRGs than they would have received under the prospective rate per discharge reimbursement system. Providers qualifying for the hold harmless provision will be limited to a 5% profit under DRGs based on the same increments of 4% as the safety net proposal (see example).

EXAMPLE OF CALCULATION OF HOLD HARMLESS PROVISION

DATA: DRG payment year - discharges 120
total DRG payments $400,000
capital & medical education payments $24,000
outlier payments $36,000

1989 base year - prospective rate $ 3,187
1990 rate increase 1.02
1991 rate increase 1.024
outlier payments $30,000

Prospective rate adjusted to reflect payments made during first year of DRG reimbursement.

1.	PPS base rate.	$ 3,187
2.	1990 and 1991 rate inc..	x 1.044
		= $ 3,327
3.	Discharges in DRG payment year . . .	x 120
		= $399,240
4.	Outlier payments.	+ 30,000
5.	TOTAL PPS HOLD HARMLESS AMOUNT	$429,240

DRG payment year adjusted total payments.

1.	Payment year DRG payments.	$400,000
2.	Capital & medical education payments	+ 24,000
3.	Outlier payments.	+ 36,000
4.	TOTAL ADJUSTED DRG PAYMENTS	$460,000

Calculation of Financial Adjustment:

100.0%	$429,240				
104.0%	$446,410 ==	$17,170	x	0%	$ 00,000
106.0%	$454,994 ==	$ 8,584	x	50%	4,292
Above	$460,000 ==	$ 5,006	x	100%	5,006
Total Recoupment					$ 9,298

Maximum Gain == $21,462 or 5.0%
Maximum Loss == Hold Harmless Amount on line 5 above

The calculation, of an amount due or payable, for this proposal will be made automatically for every provider and would be based on payments made for all applicable inpatient claims processed for the first year of DRG reimbursement. Due to the period of time from when a patient is discharged to when payment is made we will wait for six months after the first full year of DRG implementation before we request the necessary data to made this calculation and financial adjustment If a provider can document that a substantial number of claims having a significant impact on this calculation were paid after this six month period a request for an adjustment to the amount originally calculated would be granted.
In addition, providers who can document that they would have a substantial amount of reimbursement due during the year based on the above calculation may submit a request for an interim payment along with their calculation of the amount they believe is due their facility including year to date payment information supporting their calculation. The data and calculation submitted will be verified for accuracy and, if correct, an interim payment will be made. All interim payments will be applied at the time the final hold harmless settlement is made. Interim payments made under this proposal will be restricted to not more than one per quarter.

APPENDIX SECTION 27000
AREA WAGE INDICES
Effective July 1, 1996

Following wage area indices are based on wage data from the HCFA 1993-94 hospital wage survey as of March 15, 1996.

WAGE AREAS FOR WISCONSIN HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Appleton/Neenah/Oshkosh	0.9693	None
Eau Claire	0.9453	None
Green Bay	0.9860	None
Janesville/Beloit	0.9392	None
Kenosha	0.9944	None
La Crosse	0.9408	None
Madison	1.0910	None
Milwaukee County	1.0575	None
Ozaukee-Washington-Waukesha Counties	1.0335	None
Racine	0.9626	None
Sheboygan	0.8806	None
Superior, WI / Duluth, MN	1.0379	None
Wausau	1.1267	1.0145
Rural Wisconsin	0.8806	None

WAGE AREAS FOR BORDER STATUS HOSPITALS	For Original Remaining Hospitals in Area	For Hospitals Reclassified to Area
Twin Cities, Minnesota (St. Paul, Minneapolis, Coon Rapids, Edina, Lake City, Robinsdale, Stillwater, Chisago City, Hasting)	1.1797	None
Duluth, Minnesota	1.0379	None
Rochester, Minnesota	1.1384	None
Rockford, Illinois	0.9927	None
Dubuque, Iowa	0.8823	None
Chicago - Woodstock, Harvard, Illinois	1.0206	None
Iowa City, Iowa	1.0279	None
Rural Illinois	0.8415	None
Rural Minnesota	0.8795	None
Rural Michigan	0.9090	None

(Page numbers 50 to 53 not used)

TN # 96-021
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APPENDIX 27200
INFLATION RATE MULTIPLIERS
FOR ADMINISTRATIVE ADJUSTMENTS
FOR RATES EFFECTIVE ~~JULY 1, 1995~~ THROUGH JUNE 30, 1996

JULY 1 1996

Inflation rates to be applied in calculating the following administrative adjustments of section 11900:

Item B -- Capital and direct medical education payment based on cost report more than three years old

Item C -- Capital payment adjustment for major capitalized expenditures

Item D -- Adjustment for changes in medical education

Month Fiscal Year Ended	Inflation Multiplier
1990	
Jan-90	1.2550
Feb-90	1.2550
Mar-90	1.2550
Apr-90	1.2441
May-90	1.2441
Jun-90	1.2441
Jul-90	1.2260
Aug-90	1.2260
Sep-90	1.2260
Oct-90	1.2095
Nov-90	1.2095
Dec-90	1.2095
1991	
Jan-91	1.2024
Feb-91	1.2024
Mar-91	1.2024
Apr-91	1.1953
May-91	1.1953
Jun-91	1.1953
Jul-91	1.1844
Aug-91	1.1844
Sep-91	1.1844
Oct-91	1.1757
Nov-91	1.1757
Dec-91	1.1757
1992	
Jan-92	1.1680
Feb-92	1.1680
Mar-92	1.1680
Apr-92	1.1595
May-92	1.1595
Jun-92	1.1595
Jul-92	1.1474
Aug-92	1.1474
Sep-92	1.1474
Oct-92	1.1410
Nov-92	1.1410
Dec-92	1.1410

Month Fiscal Year Ended	Inflation Multiplier
1993	
Jan-93	1.1329
Feb-93	1.1329
Mar-93	1.1329
Apr-93	1.1249
May-93	1.1249
Jun-93	1.1249
Jul-93	1.1179
Aug-93	1.1179
Sep-93	1.1179
Oct-93	1.1118
Nov-93	1.1118
Dec-93	1.1118
1994	
Jan-94	1.1049
Feb-94	1.1049
Mar-94	1.1049
Apr-94	1.0990
May-94	1.0990
Jun-94	1.0990
Jul-94	1.0906
Aug-94	1.0906
Sep-94	1.0906
Oct-94	1.0832
Nov-94	1.0832
Dec-94	1.0832
1995	
Jan-95	1.0727
Feb-95	1.0727
Mar-95	1.0727
Apr-95	1.0639
May-95	1.0639
Jun-95	1.0639
Jul-95	1.0545
Aug-95	1.0545
Sep-95	1.0545
Oct-95	1.0468
Nov-95	1.0468
Dec-95	1.0468

Month Fiscal Year Ended	Inflation Multiplier
1996	
Jan-96	1.0369
Feb-96	1.0369
Mar-96	1.0369
Apr-96	1.0302
May-96	1.0302
Jun-96	1.0302
Jul-96	1.0207
Aug-96	1.0207
Sep-96	1.0207
Oct-96	1.0142
Nov-96	1.0142
Dec-96	1.0142
1997	
Jan-97	1.0063
Feb-97	1.0063
Mar-97	1.0063
Apr-97	1.0000
May-97	1.0000
Jun-97	1.0000
Jul-97	0.9903
Aug-97	0.9903
Sep-97	0.9903
Oct-97	0.9835
Nov-97	0.9835
Dec-97	0.9835
1998	
Jan-98	0.9741
Feb-98	0.9741
Mar-98	0.9741
Apr-98	0.9682
May-98	0.9682
Jun-98	0.9682
Jul-98	0.9591
Aug-98	0.9591
Sep-98	0.9591
Oct-98	0.9521
Nov-98	0.9521
Dec-97	0.9521

APPENDIX 28000
PROCEDURES FOR PROCESSING ADMINISTRATIVE ADJUSTMENTS

The Department provides an administrative adjustment procedure that allows individual hospitals an opportunity to receive a prompt review of their payment rates for specific circumstances. The policies and criteria for administrative adjustments that apply to hospitals are provided in the following State Plan sections:

(1) For inpatient rates for hospitals in Wisconsin and major border status hospitals, see §11000 of the "Inpatient Hospital State Plan".
(2) For inpatient rates for minor border status hospitals and out-of-state hospitals, see §10400 of the "Inpatient Hospital State Plan".
(3) For outpatient rates, see §6000 of the "Outpatient Hospital State Plan".

This appendix outlines the procedures the Hospital Unit staff of the Bureau of Health Care Financing (we) will follow for processing administrative adjustment requests from hospitals. Under some circumstances, an interim administrative adjustment may be provided with a final adjustment calculated after the a required audited cost report is available. The procedures in this appendix apply to the calculation of interim and final administrative adjustments.

These procedures apply to any administrative adjustment request submitted by a hospital on and after July 1, 1996

28010 Receipt of Request For Administrative Adjustment

A request for an administrative adjustment must meet the following requirements:

(1) *The request must be submitted by the due date.* A due date is specified in the state plan sections listed above for each circumstance for which an adjustment may be requested.

(2) *The request must be sufficient.* The request must inform us:
   (a) as to whether the request applies to inpatient or outpatient rates,
   (b) the specific circumstance listed in the state plan for which the hospital is requesting an adjustment, and
   (c) the effective date of the rate to be adjusted or the outpatient final settlement period to be adjusted.

Upon receipt of a request for an administrative adjustment, we will review the request and, if necessary, contact the hospital regarding the following items:

(1) We will determine if the request was submitted by the due date. If not, we will notify the hospital either:
   (a) if the request is denied because it has not been submitted by the required due date, or
   (b) if "the 60 day rule" allows the adjustment to be effective at some date other than the effective date of the rate for which an adjustment is being requested. (The "60 day rule" is described in §11600 of the "Inpatient Hospital State Plan" and §6300 of the "Outpatient Hospital State Plan".)

(2) We will determine if the request is sufficiently clear. If not, we will contact the hospital for clarification and may ask the hospital to resubmit a sufficient request.

(3) We will assess the data needed to calculate the adjustment. If additional data is needed from the hospital, we will request additional data according to the procedure described in §28020 below.

28020 Request For Additional Data

If we determine additional data is needed for the adjustment, we will contact the hospital to request the additional data and specify a due date for the hospital to submit it. The due date we specify will not be less than one month and not more than three months from the date of our request. However, if the hospital requests an extension and can justify that additional time is needed to provide accurate information, we may allow additional time for submitting the data.

If the hospital does not submit the data or an extension request within the specified time period, we will notify the hospital in writing that the administrative adjustment will be denied unless the hospital submits the requested data. With this notice, we will specify another due date for submitting the data of not less than two weeks and not more than one month from the date of this notice.

In order to calculate the administrative adjustment, we may find it necessary to request additional data more than once from the hospital. Each request for additional data will be handled as outlined above.

28030 Notification to the Hospital of Our Proposed Adjustment

After we have the needed data, we will calculate the adjustment and send a notification to the hospital of our proposed adjustment along with supporting worksheets.

We will request the hospital to review our proposed adjustment and respond only if the hospital disagrees with the calculations. We will specify a due date for a response of not less than one month and not more than three months from the date of our notification to the hospital of the proposed adjustment.

If the hospital responds with a disagreement to our calculations, we will attempt to settle the disagreement with the hospital as described in §28040 below.

If we do not receive a response from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

28040 If Hospital Disagrees With Our Proposed Administrative Adjustment

If the hospital disagrees with our proposed administrative adjustment, we will attempt to settle any disputes the hospital may have and reach an agreement. The process of settling disputes may continue until a mutual agreement is reached. It may involve our revising the adjustment one or more times. In the process of settling disputes, we may request additional data according to the procedures outlined in §28020 above.

28041 If We Do Not Revise the Disputed Adjustment.

If we do not revise the disputed adjustment, we will notify the hospital that no change will be made to the previously proposed adjustment. In this notification, we will inform the hospital that they can request a meeting with the administrative adjustment review panel and that such a request must be submitted by a due date that we will specify. (The panel is described in §28050 below.) The specified due date will not be less than one month and not more than three months from the date of this notice.

If we do not receive a request for a meeting from the hospital by the due date, we will deem our proposed adjustment accepted by the hospital and we will adjust the hospital's payment accordingly.

If the hospital requests a meeting with the review panel, we will contact the hospital to schedule a meeting.

We will not schedule a meeting with the administrative adjustment review panel until the hospital and us have attempted to reach an agreement on a disputed adjustment. We will schedule a meeting at the hospital's request only after the hospital has submitted a disagreement to our initial or first adjustment proposal and: (a) we have either responded to the hospital with at least one revised adjustment which they do not accept, or (b) we have notified the hospital that we will not change the proposed adjustment.

28042 If We Revise a Disputed Adjustment.

If we revise a disputed adjustment, we will send our revised adjustment and supporting worksheets to the hospital. With our proposing a revised adjustment, the procedures described in §28030 and §28040 above will be used for notifying the hospital and handling any disputes the hospital may have with the revision.

8050 Administrative Adjustment Review Panel

The administrative adjustment review panel serves as an advisory group to the director of the Bureau of Health Care Financing (BHCF) for final decisions on disputed administrative adjustments. The panel will be chaired by a designee of the director and will consist of at least four other staff of the BHCF. Panel members will be appointed by the director or his/her designee and will not necessarily be the same persons for each meeting or case. Up to two staff persons who are directly involved in hospital rate setting may be, but need not be, on the review panel. The staff person or persons who calculated the adjustment will not be on the review panel.

Meetings of the review panel will be scheduled with hospital consultation. The hospital's representatives may attend the meeting in person or may meet with the panel through a teleconference. In addition to meeting with the panel, the hospital's representatives may provide written position papers and other information regarding their case.

The meeting will be an informal fact finding meeting under the control and direction of the chairperson of the review panel. The BHCF staff person(s) who calculated the adjustment will explain their calculations and policy considerations and answer inquires from the panel and from the hospital's representatives. The hospital's representatives will be given the opportunity to present the hospital's case and answer inquires from the panel members and from the BHCF staff person(s) who calculated the adjustment. After hearing the presentations, the review panel will develop a recommendation for the director of the BHCF, which may include or be based on a revised calculation prepared at the direction of the panel. The panel may discuss the case without the presence of the hospital's representatives.

The BHCF director or his/her designee will make the final decision on the adjustment and will send notice of the decision to the hospital.

End of Administrative Adjustment Procedures.

SECTION 3. ADDITIONAL OPERATING PROCEDURES - The AAC

A. Purpose and Structure of the Committee

1. The Administrative Adjustment Committee was created in 1981 to review Title XIX reimbursement to hospitals as authorized by the Code of Federal Regulations. The Committee is not considered a policy-making body for the Department; rather, decisions of the AAC are advisory to officials of the Division of Health.
2. The AAC consists of ten members who are appointed by the Secretary of the Department. The composition of the Committee is as follows: three State officials, five health-care provide representatives, one representative of the health insurance industry, and one consumer.
3. AAC members are appointed for a one-year term at the beginning of each calendar year and may be reappointed an unlimited number of times.
4. The Chairperson is designated by the Secretary of the Department.
5. The AAC meets once per calendar quarter, if needed.
6. A minimum of five members shall be present in order for the Committee to act as a review body. Two of the five members shall be state officials and three of them health-care provider representatives (or two health care provider representatives and one consumer).
7. Proxies for AAC members may attend meetings, but they may neither vote nor complete a quorum.

B. Notification of Public

1. Public notice requirements established under s. 19.84, Stats., shall be met for AAC meetings.
2. Interested parties shall be, on their request, placed on a mailing list to receive a copy of the agenda.

C. AAC Meeting Protocol

1. The meeting is conducted by the Committee Chairperson.

2. New information (i.e., information not submitted via application procedures) in the form of financial and/or statistical documentation relative to a particular case shall not be accepted at the meeting. A decision may be deferred in lieu of acceptance of new information.

3. Copies of materials referred to at the meeting shall be made available to members of the general public upon their request.

4. Issues shall be discussed in the order that they are listed on the agenda, unless indicated otherwise by the Chairperson.

5. Minutes of the meeting shall be kept by a staff person to the Committee. An electronic transcription of the meeting shall be kept until such time as the minutes of the meeting have been approved by the AAC.

6. The AAC meeting may be closed to the public only according to the conditions outlined in s. 19.85(1), Stats. The meeting may be reopened according to conditions set forth in s. 19.85(2), Stats.

7. Conflict of Interest

   A "conflict of interest" is defined to exist for a Committee member when that Committee member has (or within the past twelve months, had) a substantial ownership, employment, medical staff, fiduciary, contractual, creditor, family relationship, or consultative relationship with any individual or entity involved in a case under consideration for administrative adjustment by the Committee. No Committee member shall, in the exercise of the Committee's authority to recommend decisions on AAC cases to Department officials, make a motion, vote or debate any matter before the Committee with respect to an individual or entity with which such member has a "conflict of interest" relationship as defined above. Additionally, each Committee member who has or has had such a relationship as defined above with an individual or entity involved in an AAC case, shall announce it to the Committee prior to Committee's review of the case and make such relationship public in the AAC meeting during which related action is to be taken.

a. Any Committee member may raise the question of a conflict of interest or a possible conflict of interest with respect to any Committee member present and the question shall be decided by a majority vote of all Committee members present.
b. Any disclosure of a conflict of interest and any abstained vote on a case under consideration by the Committee because of a conflict of interest shall be documented in the minutes.

8. Presentation of Issues

The Committee shall devote a maximum of thirty minutes to each case, unless the Committee Chairperson grants an extension.

1) Staff shall have three minutes to summarize both the issues and recommendations.
— If staff recommend that a case be remanded back to them on the grounds that the provider did not attempt to resolve disputes on the case with staff, the Committee may do so at this point in the proceedings. The Committee shall act in terms of motions and the vote according to the procedures outlined below.
— In addition, the Committee shall prescribe the deadline by which attempts to resolve provider and Department disputes shall be completed.
2) The provider representative shall have five minutes to present arguments pertinent to the case.
3) Staff shall have five minutes to present the Department's position.
4) The Committee may question both parties for an additional five minutes.
5) The remaining twelve minutes are reserved to the Committee for motions, discussion, and the vote.
a) A Committee member may make a motion relative to the case under consideration.
b) The Chairperson shall restate the motion to the Committee to ensure clarity, when necessary, and ask if any member seconds the motion.
c) If not seconded, the motion shall be dropped and shall not be reconsidered.
d) If seconded, the Chairperson shall request discussion.
e) Committee members may question the provider representative(s) and staff. However, provider representative(s) and staff may not request to address the Committee while motions are being discussed.
f) Motions may be amended before the vote is called.
g) The Chairperson may limit Committee discussion in light of the thirty-minute time limit per case.
h) After discussion of a motion is ended, the Chairperson shall call for a vote on the motion.
i) The outcome of the vote shall be determined by majority rule.

9. Members of the general public may participate in the meeting at the discretion of the Chairperson.

10. AAC Recommendations on Rate Cases

a. Committee decisions shall be based on the State Plan.
b. The Committee may defer making a recommendation on a case as long as it is necessary to obtain additional information.
c. AAC recommendations on deferred cases shall be made at an AAC meeting.
1) If agreement on a case can be reached between staff and the provider representative(s), the provider is not required to be present at the meeting at which the final AAC recommendation is made.
2) The State's proposed adjustment shall automatically stand if the provider did not attempt to resolve differences on the case with staff after the case was remanded back to staff for that activity.

11. Cancelled Meetings

An AAC meeting may be cancelled at the discretion of the Chairperson, if there are no disputed cases scheduled for Committee consideration.

12. Status Reports on Resolved Cases and Cases Pending
a. Staff shall prepare quarterly reports on all Administrative Adjustment cases that either have been